Department of Veterans Affairs **VHA DIRECTIVE 2002-038**
Veterans Health Administration
Washington, DC 20420 **July 5, 2002**

HOSPICE AND PALLIATIVE CARE WORKLOAD CAPTURE

1. PURPOSE: This Veterans Health Administration (VHA) Directive defines VHA responsibility in providing Hospice and Palliative Care (HPC) and VHA Policy on coding for HPC. Guidance is provided for ensuring consistent coding and facilitating accurate tracking of HPC workload in all settings to fulfill mandates of Public Law 106-117, the Veterans Millennium Health Care and Benefits Act of 1999.

2. BACKGROUND

a. Veterans' Health Care Eligibility Reform Act of 1996 (38 CFR § 17.38) mandates that VHA provide HPC services to eligible veterans who need these services. HPC are covered services, on equal priority with any other medical care service as authorized in the Medical Benefits Package. HPC services are to be appropriately provided in any outpatient setting and in any inpatient bed location.

b. In order to match services with needs, to prepare to meet changing needs, to monitor the adequacy of provision of these services, and to comply with Public Law 106-117, VHA needs accurate workload information on HPC in all settings. All HPC that is provided or purchased by VHA is to be depicted by the use of a specific International Classification of Diseases 9th Edition, Clinical Modification (ICD-9-CM) code. In addition, all HPC that is purchased by VHA is to be depicted by the use of Purpose of Visit (POV) codes within the Fee Application within Veterans Health Information System Technology and Architecture (VistA) (see Att. A for specific coding requirements).

c. A co-payment is charged for extended care services to 0 percent non-compensable service connected veterans and non-service connected veterans not meeting specific exemption criteria. Veterans in the terminal phase of illness receiving hospice care in a nursing home setting are exempt from the extended care co-payment. In order to distinguish end-of-life care that is exempt from extended care co-payment, specific hospice criteria apply to such care in nursing home settings and must be denoted using the extended care hospice treating specialty code or the hospice POV code (see Att. A).

d. **Definitions.** To facilitate appropriate delivery of services, consistent workload capture, and adherence to co-payment policy, these service definitions must be used:

(1) **Hospice and Palliative Care.** The VHA definition of HPC is all care in which the primary goal of treatment is comfort rather than cure in a person with advanced disease that is life-limiting and refractory to disease-modifying treatment; this includes bereavement care to the veteran's family.

(a) Hospice and palliative care collectively represent a continuum of comfort-oriented and supportive services provided in the home, community or inpatient settings for persons in the advanced stages of incurable disease.

THIS VHA DIRECTIVE EXPIRES JULY 31, 2007

(b) Hospice is a mode of palliative care, often associated with specific characteristics of the individual receiving the care: afflicted with a known terminal condition, prognosis less than 6 months, and relinquishing all aggressive and curative care.

(c) Palliative care is a broader term that includes hospice care as well as other care that emphasizes symptom control, but does not necessarily require the presence of an imminently terminal condition, a time-limited prognosis, or exclusion of all aggressive or curative therapies. Palliative care may include a balance of comfort measures and curative interventions that varies across a wide spectrum.

(d) The goal of HPC is to achieve the best possible quality of life through relief of suffering, control of symptoms, and restoration of functional capacity while remaining sensitive to personal, cultural, and religious values, beliefs and practices. Programs emphasize the comprehensive management of the physical, psychological, social and spiritual needs of the patient.

(e) To emphasize the importance of a continuum of services that are to be appropriately provided in any care setting, these services are referred to collectively as "hospice and palliative care "(HPC) rather than demarcating hospice from palliative care. ***NOTE:*** *Similarly, for the purpose of workload capture and coding, HPC is treated as a unified set of services.*

(2) **Hospice Care**

(a) The VHA definition of hospice care is all care provided to veterans meeting four criteria:

1. Diagnosed with a life-limiting illness;

2. Treatment goals focus on comfort rather than cure;

3. Life expectancy is determined by a VA physician to be 6 months or less if the disease runs its normal course, consistent with the prognosis component of the Medicare hospice criteria; and

4. Accepts hospice care.

(b) The term "hospice," as differentiated from "palliative care," is used within VHA to denote care in the terminal phase of illness to a veteran meeting these four criteria, in order to distinguish end-of-life care that is exempt from extended care co-payment: hospice care provided in a nursing home setting**.**

NOTE: *Recognizing that prognosis cannot be predicted with certainty, physicians are advised to use the National Hospice and Palliative Care Organization's Medical Guidelines for Determining Prognosis in Selected Non-Cancer Diseases, Second Edition" (see Att. B for synopsis). While these prognostic guidelines are useful in determining eligibility for the Medicare hospice benefit, they are to be used as a guide, not a rigid requirement. Some patients appropriate for hospice will survive longer than 6 months. Periodic reevaluation of patients,*

their prognoses, and their expected benefit from hospice care needs to be documented in the care plan.

3. POLICY: It is VHA policy that each VA medical center Director is responsible for ensuring that the proper ICD-9-CM, POV, and treating specialty codes are used for all HPC.

4. ACTION: Each VA medical center Director, or designee, is responsible for:

a. Reviewing facility HPC services to ensure that clinical staff denote "Hospice" or "Palliative Care" in the medical record whenever palliative care is the primary goal of care, and "Hospice" when consistent with the VHA definition.

b. Ensuring that such care is coded using ICD-9-CM code V66.7 for all HPC, and specific treating specialty codes and POV codes as detailed in Attachment A. ***NOTE:*** *Medical prognostic guidelines are identified in Attachment B, and if further information is needed, through the Office of Geriatrics and Extended Care (114), VA Central Office.*

c. Ensuring that the following mandated coding guidelines are used:

(1) **Coding for Hospice and Palliative Care Provided by VHA Staff.** HPC provided by VHA staff to veterans in a VA facility, VA clinic, or in the home of the veteran must be clearly distinguished as "Hospice" or "Palliative Care" in physician orders, in the admission note, or in the outpatient progress note. Bereavement services are an integral component of hospice care, and need to be similarly noted. Specific ICD-9-CM coding guidelines must be followed, and HPC is to be coded with the secondary ICD-9-CM code V66.7 (see Att. A). A separate primary diagnosis must also be noted and recorded.

(a) For example, a veteran with advanced dementia may be receiving outpatient HPC consistent with the expressed primary goal of comfort, and then develop a hip fracture from a fall. Surgical repair of the hip fracture may be appropriate, with the goals of reducing pain and promoting maximal mobility. The principal diagnosis and Treating Specialty are to reflect the hip fracture and those providing the treatment. If the admission orders or admission note indicate "Hospice" or "Palliative Care" then a secondary code (ICD-9-CM code V66.7) will be included.

(b) In another situation, if a veteran has been receiving curative care in one VA setting, and the primary goal of care later is changed to comfort care, then any transfer to another service is to have "Hospice" or "Palliative Care" noted in the admission orders or admission note by the receiving care team. Medical record documentation requirements must be followed to substantiate the type of care provided, and ICD-9-CM code V66.7 must be included as the secondary diagnosis for each encounter.

(2) **Coding for Hospice Care Provided in a Nursing Home.** Hospice care provided in a nursing home setting to veterans in the terminal phase of illness is exempt from the extended care co-payment. Veterans meeting the VHA definition for hospice care who receive this care in a VA nursing home setting must be assigned the Extended Care Hospice Treating Specialty Code 96. Veterans meeting the VHA definition for hospice care who receive hospice care in a VA-

paid community nursing home bed through the Community Nursing Home (CNH) program must be assigned CNH Hospice POV code 43. The appropriate ICD-9-CM codes must also be used, including the secondary code V66.7 for HPC workload capture.

(3) **Coding for Hospice and Palliative Care purchased by VHA.** All episodes of HPC that are purchased by VHA and provided in a non-VA setting are required to be entered into the Fee Application within VISTA and denoted with POV codes through the Fee Package. The CNH Hospice POV code 43 must be used for every VA-paid episode of CNH care meeting the VHA definition of hospice care, as this care is exempt from extended care co-payment. The POV codes for outpatient HPC need to be used for purchased outpatient services meeting the VHA definition of "hospice and palliative care." Standard co-payment policy applies. See Attachment A for the use of POV codes for hospice and palliative care. The appropriate ICD-9-CM codes must also be used, including the secondary code v66.7 for HPC workload capture.

d. Ensuring that proper Decision Support System (DSS) and Cost Distribution Report (CDR) accounts support the preceding codes.

5. REFERENCES

a. American Hospital Association Coding Clinic, First Quarter, 1998, pages 11-12;

b. Medical Guidelines for Determining Prognosis in Selected Non-Cancer Diseases, Second Edition, The National Hospice Organization, 1996.

6. FOLLOW-UP RESPONSIBILITY: The Geriatrics and Extended Care Strategic Healthcare Group (114) is responsible for the contents of this Directive.

7. RESCISSIONS: This VHA Directive expires July 31, 2007.

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Under Secretary for Health

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ATTACHMENT A

HOSPICE AND PALLIATIVE CARE: CODING RULES

1. Definition. The Veterans Health Administration (VHA) definition of hospice and palliative care (HPC) is all care in which the primary goal of treatment is comfort rather than cure in a person with advanced disease that is life limiting and refractory to disease-modifying treatment.

a. For VHA workload capture, HPC services are treated as a single spectrum of care and assigned International Classification of Diseases 9th Edition, Clinical Modification (ICD-9-CM) code V66.7.

b. For discernment of extended care co-payment, "hospice" is defined in VHA as all care provided to veterans meeting four criteria:

(1) Diagnosed with a life-limiting illness;

(2) Treatment goals focus on comfort rather than cure;

(3) Life expectancy is determined by a Department of Veterans Affairs (VA) physician to be 6 months or less, if the disease runs its normal course, consistent with the prognosis component of the Medicare hospice criteria; and

(4) Accepts hospice care. This hospice care is identified by specific Treating Specialty or purpose of visit (POV) codes.

2. Coding for Workload Capture. All HPC that is provided or purchased by VHA is to be depicted by the use of ICD-9-CM code V66.7. This ICD-9-CM code V66.7 is to be used for HPC in any inpatient, outpatient or home care setting. Note that code V66.7 is a secondary diagnosis code and must be accompanied by a primary diagnosis code. V66.7 Encounter for palliative care (end-of-life care; hospice care; terminal care) ICD-9-CM Diagnosis Tabular List.

3. Coding in Addition to HPC Workload Capture. Other coding in addition to ICD-9-CM V66.7 must be applied specific to the circumstance, as described in the following sections.

4. Coding Instructions for Care Provided by VA Staff. The coding of HPC that is provided directly by VA staff, whether in an inpatient facility, an outpatient clinic, the home of a veteran, or other setting, will follow these instructions:

a. **Inpatient Care.** The secondary diagnosis will indicate HPC, using ICD-9-CM code V66.7 for all care meeting the VHA definition of HPC. A separate principal diagnosis code must be included. The principal diagnosis is the condition, after study, that is determined to be the reason for admission. Treatment of principal diagnosis may involve hospice or palliative care, but HPC cannot be listed as the principal diagnosis. An example follows:

Question: A patient is admitted with end-stage lung cancer, for palliative care only. How should this be coded?

Answer: Assign code 162.9, Malignant neoplasm of bronchus and lung, unspecified, and code V66.7, Encounter for palliative care (see American Hospital Association (AHA) Coding Clinic, 4th Quarter, 1996; and AHA Coding Clinic, First Quarter, 1998, pages 11 and 12).

b. **Nursing Home Care.** The Treating Specialty code 96 for hospice care in a VA extended care inpatient setting must be used when a veteran is admitted to a VA nursing home bed for hospice care and meets all four VHA hospice care criteria.

c. **Outpatient Care.** If the primary goal of care meets the HPC definition, then HPC ICD-9-CM code V66.7 needs to be listed as a secondary diagnosis code. In addition, a separate primary diagnosis code must be included. The primary diagnosis is the primary reason for the encounter, i.e., congestive heart failure.

5. Coding Instructions for Non-VA Care, Paid for by VA

a. For non-VA care that is purchased by VA, processing authorizations and payment of invoices for HPC require the use of the Veterans Health Information System Technology and Architecture (VistA) Fee Basis Application. User instructions can be found in the Fee Basis User Manual and Fee Basis Guidebook, through the Austin Automation, Fee Web site at http://vaww.aac.va.gov/fee/.

b. Patch FB*3.5*34 was released September 18, 2001. Pertaining to hospice and palliative care, one new purpose of visit (POV) code for hospice care was added, and two existing hospice POV codes were redefined, to support reporting of extended care.

(1) The Fee Basis Patch and descriptions for POV codes 43, 77 and 78 follow. CNH Hospice POV code 43 is to be used when the veteran meets all four VHA hospice care criteria, and agrees to receive hospice care through the Community Nursing Home (CNH) Program. Outpatient HPC POV codes 77 and 78 are to be used for care that meets the VHA HPC definition.

(2) Fee Basis Patch, FB*3.5*34 for POV codes 43, 77, and 78

43	Inpatient	CNH Hospice (new)
77	Outpatient	Hospice and Palliative Care (OPT)-Contract and/or Sharing Agreement (renamed)
78	Outpatient	Hospice and Palliative Care (OPT) – Fee Basis Authority (Title 38 Code of Federal Regulations (CFR) 17.50b) (renamed)

ATTACHMENT B

ESTIMATING PROGNOSIS IN NON-CANCER DISEASES

NOTE: *Adapted from Medical Guidelines for Determining Prognosis in Selected Non-Cancer Diseases, 2nd Ed,. National Hospice Organization, Arlington VA, 1996.*

The following are guidelines; fulfilling the criteria for any of the categories supports that a patient has a prognosis less than 6 months, and may be deemed appropriate for hospice care and referral for the Medicare hospice benefit. ***NOTE:*** *Other criteria may apply.*

1. General. The patient meets all the following:

a. Life-limiting condition;

b. Treatment goals are for comfort rather than cure;

c. In the past 6 months, the patient has either documented terminal disease-related decline in nutritional status (weight loss >10 percent) or clinical progression of disease (repeated emergency room or inpatient admissions, or functional status decline).

2. Congestive Heart Failure. The patient meets, on optimal treatment:

a. Class IV heart failure or ejection fraction < 20 percent; and

b. Syncope, cardiac arrest, cardiogenic stroke, or symptomatic arrhythmia.

3. Chronic Obstructive Pulmonary Disease. The patient meets some of the following:

a. Dyspnea at rest unresponsive to bronchodilators. Forced Expiratory Volume (FEV1) after bronchodilator less than 30 percent of predicted.

b. Dyspnea limits walking to a few steps.

c. Resting pCO2 > 50; O2 Saturation < 88 percent or pO2 < 55 on supplemental oxygen; Cor pulmonale.

d. Weight loss > 10 percent of body weight; resting tachycardia > 100.

4. Renal Failure. Chronic renal failure with creatinine > 8.0 mg/dL, off dialysis.

5. Cirrhosis and/or Liver Failure. With clinical judgment, the patient:

a. Spends most time in bed, INR > 1.5, albumin < 2.5 g/dL.

b. Evidences comorbidity: encephalopathy, spontaneous bacterial peritonitis, refractory ascites, recurrent variceal bleeding, hepatorenal syndrome, or wasting.

6. Dementia. The patient meets all the following:

a. Speech limited to 6 words;

b. Bed-bound;

c. Incontinent;

d. Unable to ambulate, dress, and bathe without assistance; and

e. A comorbidity in prior year; i.e., pyelonephritis, pressure ulcer, sepsis, fever after antibiotics, difficulty feeding with aspiration pneumonia or weight loss > 10 percent.

7. Human Immunodeficiency Virus (HIV) Disease. The patient meets some of the following:

a. CD4+ count below 25 cells/μL;

b. Viral load > 100,000/ml;

c. Declining functional status;

d. Certain opportunistic infections;

e. Albumin < 2.5 g/dL.

8. Strokes and/or Coma

a. **Acute Phase.** The patient meets any of the following:

(1) Coma or persistent vegetative state 3 days after stroke.

(2) Any four of the following on day three of coma:

(a) No verbal response.

(b) Abnormal brain stem response.

(c) No response to pain.

(d) Serum creatinine > 1.5 mg/dL, Age > 70.

(e) Dysphagia preventing adequate intake in a patient who is not a candidate for artificial nutrition.

b. **Chronic Phase.** The patient meets some of the following:

(1) Poor functional status;

(2) Dementia dependent in ambulation, dressing, bathing and toileting;

(3) Weight loss > 10 percent, albumin < 2.5g/dL.

(4) Complications to include: aspiration pneumonia, pyelonephritis, sepsis, stage three or four decubitus, and/or fever after antibiotic.

9. Amyotrophic Lateral Sclerosis (ALS). The patient evidences a rapid progression of ALS, with decline in one of the following:

a. Ventilatory capacity,

b. Swallowing, or

c. Functional status.

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